

The following report follows the guidelines issued by the United States Department of Education, Office of Special Education Program (OSEP), for each state's Annual Performance Report for Part C of the Individuals with Disabilities Education Act (IDEA) for the past fiscal year (July 1, 2000, through September 30, 2001).

1. A description of activities undertaken and progress made, with regard to the status of the statewide system of early intervention services. Include a description of:

- a: State agencies and their involvement in the provision of the statewide system of early intervention; and the results of interagency agreements and other interagency collaborative efforts that support or enhance the statewide systems of early intervention services to eligible children and their families**

Since 1991, the Rhode Island Department of Health (HEALTH) has been the lead agency for the Early Intervention (EI) system. The Division of Family Health is responsible for the EI system, and the Chief of EI Services serves as the Part C Coordinator and staffs the Interagency Coordinating Council (ICC) in its advisory responsibilities to HEALTH and the Governor.

The purpose of the EI system is to promote the growth and development of infants and toddlers with developmental challenges. The system serves eligible children from birth to three and their families. The foundation of the EI system is the collaboration between families and professionals.

On January 1, 2001, it was no longer business as usual for EI in Rhode Island. On that day, a new, modified, and expanded EI system was implemented, which features fee-for-service reimbursement, statewide services, family choice on location of services, incentives for reaching hard to reach families, clear standards, a new management information system (MIS), expanded technical assistance, and training and coordination of parent consultants through the Rhode Island Parent Information Network (RIPIN) to provide peer support.

Providers are now required to be certified by HEALTH in order to be a designated provider of comprehensive EI services and be eligible for reimbursement for providing services. Certification requires demonstration of capacity to comply with HEALTH's Certification Standards for EI Services. These standards are divided into eleven core areas:

1. Compliance Assurance and Management/Support by HEALTH
2. Child Find System
3. EI Services in Natural Environments
4. Family Centered Services
5. Early Childhood Transition
6. Comprehensive Public Awareness
7. Continuous Quality Improvement
8. Maximizing Reimbursement
9. EI Management Information System (EIMIS)
10. Intra-State Capacity
11. Organizational Capacity

This new EI system provides statewide services, there are no longer regional designations. Benefits of

statewide access include expansion of family choice, expansion of quality service options through an increased network of services and improvement of EI services via a richer service environment. The seven providers of statewide EI services are:

- | | |
|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Children's Friend and Service
621 Dexter Street
Central Falls, RI 02863
401-729-0010 | 5. James L. Maher Center
120 Hillside Avenue
Newport, RI 02840
401-848-2660 |
| 2. Family Service
55 Hope Street
Providence, RI 02906
401-331-1350 | 6. Meeting Street
667 Waterman Avenue
East Providence, RI 02914
401-438-9500 |
| 3. Family Resources Community Action
245 Main Street
Woonsocket, RI 02895
401-766-0900 | 7. Trudeau Memorial Center
250 Commonwealth Avenue
Warwick, RI 02886
401-823-1731
and
350 Kingstown Road
Narragansett, RI 02882
401-783-6853 |
| 4. Hasbro Children's Hospital
593 Eddy Street
Providence, RI 02903
401-444-3201 | |

In addition, Rhode Island utilizes three statewide comprehensive service units for specialized EI services: RI School for the Deaf (RISFD), Department of Education (RIDE) and Department of Human Services (DHS) Vision Program, and the Groden Center. The RISFD serves infants and toddlers who are deaf or hard of hearing, the RIDE & DHS program serves children who are blind or visually impaired, and the Groden Center serves infants and toddlers who have social-emotional and/or behavioral problems.

In September of 2000, HEALTH awarded a contract to the Rhode Island Parent Information Network (RIPIN) to oversee the Parent Consultant Program for Early Intervention. RIPIN is a nonprofit family organization whose mission is to strive to make a better life possible for children by empowering families with knowledge, skills, understanding, resources, and confidence, and by advocating for responsive systems, institutions, organizations, and communities.

Through this contract, RIPIN partners with HEALTH's EI Program, as well as the seven statewide full service EI Providers, to provide parent consultant services. RIPIN recruits, hires, supports and supervises Parent Consultants who work with the seven individual providers. Parent Consultants are parents/family members who have been through the EI system themselves and have personal knowledge of the process and the resources, supports, and services that are available to families with young children. Through this funding, RIPIN also developed a program to support fathers who have children in EI and supervises a Parent Consultant whose duties include statewide training for families/staff in EI, collaborating with the University of Rhode Island (URI) Family Resource Partnership, and quality assurance activities.

Parent Consultants have a critical role in working with the providers on various levels that include but are not limited to: working one-to-one with parents and hosting activities for families; working with the staff

on family-centered goals for families and providers; and acting as a voice and advocate for all families at the state level on various committees, task forces, and other meetings that impact families of children with special needs. This includes several quality assurance strategies, including a family satisfaction survey and the review of records.

Additionally, this contract supports the development and updating of the EI Central Directory in English and Spanish, that is available to all families in EI, as well as to the staff who support them.

Part C is designed to assure the comprehensive, coordinated, multidisciplinary, provision of EI services. For this reason, interagency agreements are required, by regulation, between the lead agency and each state-level agency involved in the State's delivery of EI services.

- HEALTH has formalized interagency agreements with the following agencies to further strengthen the statewide service delivery network: the Department of Children Youth and Families (DCYF); the Department of Education (RIDE); and the Department of Mental Health, Retardation and Hospitals (MHRH), which are actively collaborating with the Department of Human Services (DHS) CEDARR (Comprehensive Evaluation, Diagnostic, Assessment, Referral, Re-evaluation) initiative to create a unified, coordinated, and integrated system of services and supports for children with special health care needs and their families.
- The Partnership with URI: This partnership includes parents, HEALTH's EI system and faculty from varied disciplines at URI, such as human development and family studies, psychology, education, communication disorders, physical therapy, cooperative extension. The ultimate goal of this partnership is the provision of quality services to young children with developmental challenges. All partnership activities include students, exposing them to work on problems critical to RI youth. The following is a list of those activities:
 - implement an assessment of in-service training needs for each EI provider in collaboration with EI's Comprehensive System of Personnel Development (CSPD) training committee
 - collaborate with EI on an ongoing self-assessment and quality improvement process, utilizing the guidelines of OSEP
 - a system's assessment model that helps address financial benefits to the state when a child/family receives EI services, longitudinal follow-up of children in EI programs (EIP's), programmatic assessment of services to children in EIP's and assessment of collaboration with other local and state offices/programs/agencies that deliver services to children and families
 - pursue additional funds for research involving early childhood initiatives; sources include federal grants and foundations
- HEALTH (Part C) and RIDE (Part B) worked together on the self-assessment process of the United States Department of Education, OSEP Continuous Improvement Monitoring Process (CIMP).

The self-assessment process in Rhode Island was designed to collect and analyze data about the status of services currently being provided and to produce a Self-Assessment Report for submission to OSEP and for use by HEALTH and RIDE in developing an Improvement Plan to address identified needs.

The self-assessment process was a unified and public driven partnership to improve results for children with disabilities. A total of 97 individuals representing a broad range of constituents with diverse perspectives participated in the Rhode Island process on the CIMP Steering and Cluster Committees. Part C and Part B constituencies worked in concert to facilitate a coordinated birth to age twenty-one systems perspective.

To develop and implement the self-assessment, the state appointed and worked with a Steering Committee, composed of key stakeholders. The Steering Committee coordinated Rhode Island's overall process, using a subcommittee structure known as "Cluster Committees" to conduct the self-assessment related to "clusters" of specific "indicators" identified by OSEP related to IDEA requirements. Seven Cluster Committees were formed to assess Rhode Island's performance in the following eight federal cluster areas:

1. General Supervision
2. Early Childhood Transition
3. Secondary Transition
4. Family Centered Services
5. Parent Involvement
6. Early Intervention Services in Natural Environments
7. Free Appropriate Public Education in the Least Restrictive Environment
8. Comprehensive Public Awareness and Child Find System

Each Cluster Committee reviewed numerous federal and state data sources concerning Rhode Island. They analyzed this data and used a modified consensus process to identify Rhode Island's strengths and concerns most supported by the data for their respective cluster area. The Cluster Committees produced eight cluster reports, which detail their results.

In addition, numerous statewide strategies were utilized to garner additional public input including forums, questionnaires, surveys, news releases, mailings, and focus groups. The Steering Committee used this public input to identify themes to validate the strengths and concerns identified by the Cluster Committees.

In conducting the self-assessment, gaps in data were discovered that were most essential in supporting effective improvement planning. These gaps were identified as data needs to be addressed as Rhode Island continues with the Improvement Plan of the CIMP process. The Improvement Planning phase of the CIMP will continue to be a unified and public driven partnership to improve results for children with disabilities. Rhode Island will use the same joint Part B and Part C approach for system change used during the self-assessment. The prioritization of major themes and linkage to public input, as well as the ideas for improvement/maintenance strategies from this phase, will facilitate Rhode Island's transition to this next level of the CIMP.

- HEALTH, RIDE, and the University Affiliated Program (UAP) collaboratively created the position of Early Childhood Transition Coordinator to provide a focus for work on transition systems issues.

A more concentrated effort has begun to collect useful information on the current state of transition

in Rhode Island. RIPIN is overseeing the implementation of an ongoing survey procedure for families who have exited EI. Surveys have also been sent to EI staff and to preschool personnel.

A final report will be available shortly, but certain themes are already clear. EI providers are asking for much more training on the transition process itself and information about the receiving system. They want a framework for determining district level policies and procedures (a particular challenge since EI went to statewide access). Local Education Authorities (LEAs) want discussions with EI providers about evaluations/assessments and more information earlier and in more consistent written formats. Both EI and LEAs say things “fall apart” when recommended timelines are not followed.

A statewide Transition Network is being organized to create a constituency for positive change within and across the two systems. There is representation from HEALTH and RIDE, from RIPIN, from the EI Parent Consultant Program, from a variety of LEAs, and from each EI provider agency. Models of innovative and collaborative practice will be developed, as well as materials and resources created for families and providers. Each participant will engage and update their own programs or constituencies. Each will be expected to take responsibility for disseminating information and strategies and for implementing changes.

A subcommittee of the ICC is beginning to meet to determine outcome measures and ways to track state transition initiatives based on a consensus of priorities.

- Through an interagency agreement with DHS, Medicaid makes payments to qualified service providers for EI services rendered to eligible recipients of the Medical Assistance Program and, in return, HEALTH provides utilization review and quality assurance for these services.
- Those health plans participating in RItE Care, RI's Medicaid Managed Care Program, and HEALTH's EI system have agreed to work together to ensure that children enrolled in RItE Care and in the EI system receive medically necessary occupational therapy (OT), physical therapy (PT), speech/language (S/L) therapy, and associated transportation and interpreter services in a manner that is coordinated with primary care and other services they receive through their health plan membership.
- HEALTH and DCYF have a cooperative agreement regarding the appointment of surrogate parents for children in DCYF care who access EI services. The cooperative agreement addresses the recruitment, training, and monitoring of surrogate parents. DCYF also has active representation on the ICC and the CIMP of special education services from EI and RIDE.

DCYF also supports several programs that provide services to children birth to three who are at risk for developmental, health, or social problems. Project Connect, Project Early Start and Enhanced Early Start are examples of community based programs which serve the birth to three population and their families.

- Assistive Technology Access Partnership (ATAP): The Division of Family Health participates on the ATAP, whose mission is to increase the availability and accessibility of assistive technology for people with disabilities (e.g., toy fairs to spotlight the use of high and low assistive technology devices for children enrolled in EI held around the state).

- In response to needs identified by providers or by community representatives, HEALTH has convened a number of interagency and parent work groups this past year. Topics addressed by the work groups have included community partnership, very low birth weight infants, accessing durable medical equipment for young children, revisions to the statewide IFSP form, and supporting collaborative programming among EI providers for families:
 - The community partnership focus has mainly been on strengthening the RI Child Find System. Next steps being considered are facilitating a closer working relationship with WIC programs.
 - The very low birth weight group has worked to set practice guidelines for these infants and will continue that endeavor this year, along with continuing to develop stronger working relationships with NICU discharge planners.
 - The durable medical equipment group is in the process of developing a written document to help direct service providers understand RI's process for accessing equipment and provide suggestions for facilitating that process. The group is also working to identify possible solutions to barriers in the process with the intent to share this information with the ICC.
 - The IFSP work group's suggested revisions to the IFSP will be incorporated into HEALTH's next revision of that document.
 - The collaborative programming workgroup in conjunction with HEALTH developed procedures to coordinate and bill for children who are receiving services from more than one EI provider.
 - A new group focusing on evaluation and assessment in EI is in the process of being formed.

b: Innovative service delivery models, particularly in the area of natural environments (optional)

As a result of the recent CIMP, the following strengths have been identified in the area of natural environments:

- HEALTH is attempting to reimburse for services in natural environments in a way that will support programs providing these services.
- A system is in place to gather information from families regarding families' satisfaction with early intervention services.
- HEALTH is randomly sampling IFSPs for quality as part of its quarterly/annual review process.
- The state monitoring system has the ability to capture information about some specific questions.
- A Central Directory is available to inform families and providers.

c: Sources of funding and other support (public and private) for early intervention services, and the level of funding and type of activities supported, by source

Sources of funding and other support for EI services are as follows:

- Annual appropriation by the RI General Assembly to HEALTH
- Annual appropriation by the RI General Assembly to other human service agencies for the provision of related components to EI services
- Title XIX (Medicaid and EPSDT) funds
- Insurance carrier reimbursements
- Private agency funds
- Title V (MCH) funds (in kind)
- Part C of IDEA
- Any medical program administered by the Secretary of Defense

In all cases, by federal and state laws, HEALTH is the payer of last resort for the provision of EI services. HEALTH is responsible for identifying and coordinating all available resources for EI services within the state, including those from federal, state, local, and private sources. Private agencies housing EI providers have often contributed funding when there were no other available resources.

HEALTH is responsible for establishing and updating information on funding sources policies related to the payment of EI services if a legislative or policy change is made under any of those sources. These policies are also reflected in interagency agreements. HEALTH works closely with other state agencies to identify appropriate routes of access to funding and makes recommendations to the ICC, Governor, and General Assembly on legislative and/or regulatory amendments required to support access to multiple funding sources.

The reporting period for this document is 7/1/00 to 9/30/01. State funding for state fiscal year 2001 (7/1/00 to 6/30/01) was increased by \$675,000, and by \$460,00 for state fiscal year 2002 (7/1/01 to 6/30/02). Additionally, accessing Medicaid funds for providing direct services to families increased by \$248,000 between state fiscal years 1999 and 2000 and increased by \$153,804 between state fiscal years 2000 and 2001.

d: Analysis of disputes filed with the State including timelines, issues and resolution for: (i) state complaints, (ii) mediation and (iii) due process hearings

As is noted throughout this report, this has been a year of many firsts for EI in Rhode Island; this extends to the first and so far only formal complaint or request filed with HEALTH which resulted in mediation or due process hearing. A summary analysis of that dispute follows:

On June 20, 2001, a parent requested mediation to address his concerns that the frequency of his son's speech therapy was not sufficient to support his son's developmental progress. The EI provider was providing one hour of individual speech therapy a week, in addition to a placement in a language-based group and other therapeutic and behavioral supports. The parent was requesting that an hour of speech therapy per day be provided.

The first mediation session was convened on July 9, 2001. In that session, the question of obtaining an outside evaluation was raised. That issue and the frequency of speech therapy were not resolved, and a second mediation session was scheduled. In the reconvened session, held on July 16, 2001, a resolution

was reached between the EI provider and the parent. The mediation agreement included maintaining all current services with an increase in speech therapy to two times per week. In addition, the parent planned to seek placement of his son in a private behaviorally oriented program. The EI team agreed to work to coordinate services with that program. The parent also planned to pursue obtaining an outside evaluation, only if needed by the private behavioral program.

e: Analysis of children referred to the child find system, including the referral sources (physicians and other allied health personnel, parents, child care providers, etc.)

Children Referred: At birth, all infants born in Rhode Island are screened to determine eligibility for various programs, including follow-up in home visits and EI, as well as referral to other community agencies. The addition of screening for hearing loss to the universal newborn screening protocol has resulted in one of the most comprehensive screening programs nationwide. These screening programs serve as a component of EI's child find system.

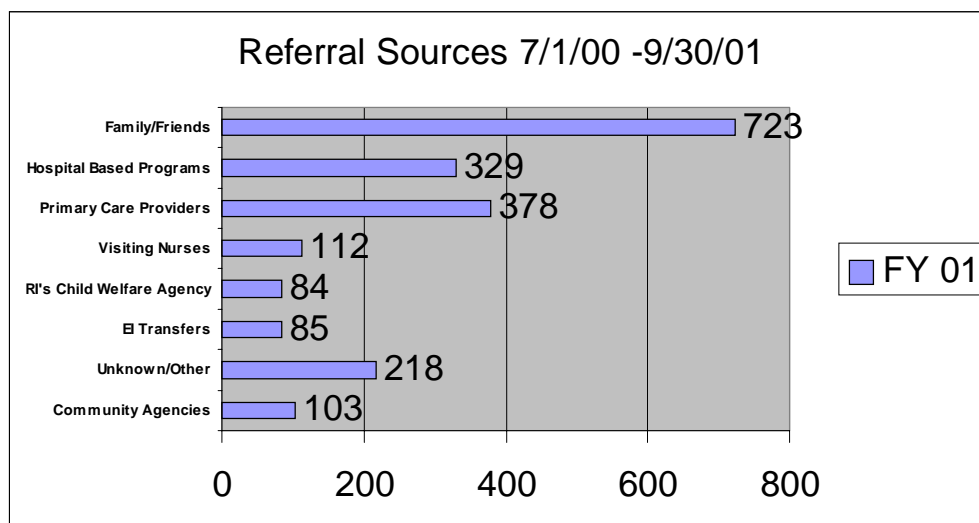
For those infants and families with qualifying diagnoses, referrals are made directly to EI providers. For those infants and families eligible for follow-up home visits, information is gathered over time about the infant's developmental competence, family strengths, needs, support systems, and the quality of the caregiving environment. Gathering this information permits the identification of those older infants in need of a referral to EI and those families who may be eligible for services and supports from other agencies.

The percentage of Rhode Island's birth to three population receiving EI services continues to gradually rise:

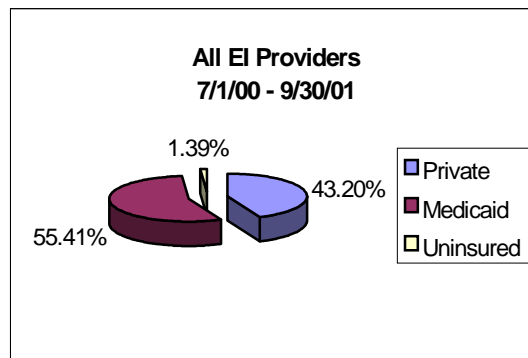
9/99	5.1%
9/00	5.4%
9/01	5.6%

HEALTH continues its public awareness efforts to outreach to hard-to-reach families in need of EI services by collaborating with state and community agencies to establish a referral network for the program. The overriding goal of these efforts is the empowerment of families to make their own referrals.

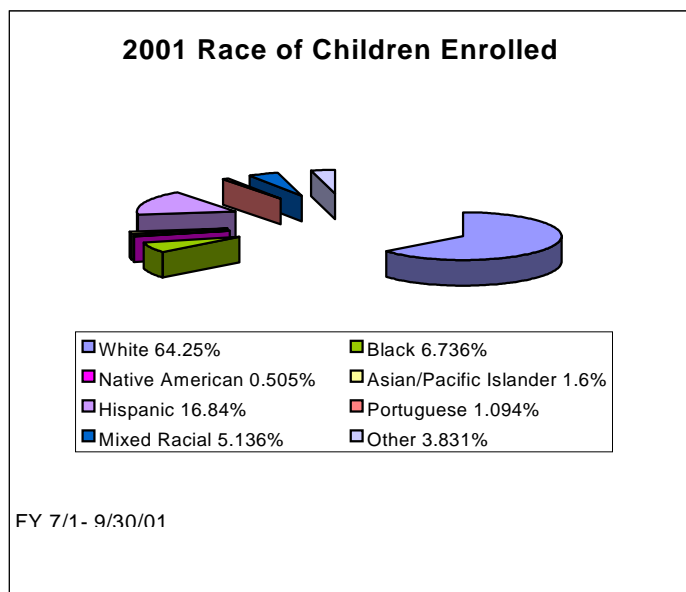
In the period 7/1/00 – 9/30/01, there were 2,375 enrollees in EI. In the same time period, there were 2,032 referrals, 723 or 36% were referred by parents/guardians, and 490 or 24% from community-based health care providers, i.e., physicians and visiting nurse associations (**Figure 1**). Overall, the number of referrals from individual families and community-based health care providers accounted for 60% of the total referrals. This compares to 58% (34% parents/guardians and 24% community based health care providers), as reported in last year's annual report.

Figure 1

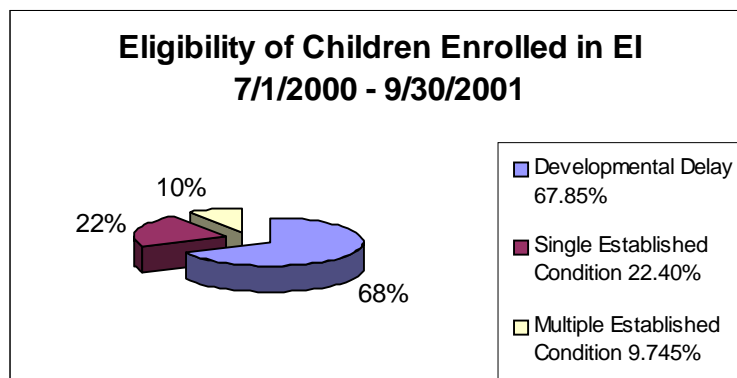
Children Enrolled: From 7/1/00-9/30/01, 1,026 children enrolled in EI (43%) had commercial medical insurance which provided minimal reimbursement for EI services, while 1,318 (56%) of children enrolled in EI were covered by some form of public health insurance, i.e., Medicaid. Compared to last year, this represents a 2% increase in the percentage of those with commercial medical insurance and a corresponding 2% decrease of those with public health insurance. Public health insurance includes those eligible for RIte Care, which covers medically necessary OT, PT, and S/L therapy services to children enrolled in EI, up to a limit of \$3,000 per year per child; the Family Independence Program (formerly AFDC); Supplemental Security Income (SSI); Katie Beckett; and EPSDT (**Figure 2**). Thirty-one (1%) were in the process of obtaining some form of health insurance coverage.

Figure 2

The racial-ethnic background of the active caseload continues to be predominately white, 64% of the total EI population. However, 36% of the EI population is of minority status, which is significant when compared to the overall state population of 27% minority for children under 3 years of age (**Figure 3**). Compared to last year, the 36% represents a 1% increase in the percentage of the EI population of minority status.

Figure 3

In terms of eligibility, 68% of the children were developmentally delayed, 22% were determined to have a single established condition, and 10% were determined to have multiple established conditions, which adversely impact on development (**Figure 4**). Compared to last year, this represents a 2% increase in the diagnosis of developmental delay and a corresponding 2% decrease with a single established condition.

Figure 4

f: Any barriers, challenges, future steps/actions related to interagency coordination

Barriers and challenges related to interagency cooperation: The Governor's Commission to Study the EI Program, which issued its final report on June 3, 1999, produced four recommendations related to interagency cooperation:

1. The Commission recommends the development of formal interagency agreements and a meaningful merger of resources among State Departments, such as the Department of Education; the Department of Children, Youth and Families; the Department of Human Services; and the Department of Health. A seamless system needs to be developed that strengthens the link between EI services and services for children from ages three to five years old.

2. The Commission recommends the development of processes to bring linguistically and culturally sensitive EI services and supports to community locations where high risk newborns with critical needs receive health care, such as Hasbro Children's Hospital Pediatric Intensive Care Unit and Pediatric Primary Care Clinic, the Providence Ambulatory Health Centers, Women and Infants Hospital Neonatal Intensive Care Unit, and the Neighborhood Health Centers.
3. The Commission recommends that the EI System build upon current interagency linkages and assist EI providers to establish a local multi-agency service base that includes health providers, generic service providers, and typical community businesses and organizations.
4. The Commission recommends the development of a greater number of community resources, such as quality day care centers, that will accept children eligible for EI into integrated programs and from which parents can choose services and supports that meet their needs and those of their children.

Plans and Actions Related to Interagency Cooperation:

- A system that maximizes Medicaid revenues for children enrolled in EI through a HEALTH and DHS interagency coordinating team
- Medicaid service definitions and rates have been made clearer and more widely disseminated
- Training for EI providers on Medicaid billing and reimbursement issues
- Continue to coordinate with the DHS, DCYF, MHRH and RIDE through staff support and coordination to integrate EI activities with the CEDARR Initiative
- Planning has begun with RIDE to integrate training systems to address EI and pre-school transition issues
- Establishment of a culturally diverse Parent Consultant Program through RIPIN to support families receiving EI services
- Reconstituted the ICC to reflect a broader EI system and to increase parent membership from four to ten
- Expansion of access to the Central Directory, including internet access, an information help line staffed by parents and an array of training for families and interagency groups
- Expansion of child care options: The Child Care Support Network (CCSN), funded jointly by DHS and HEALTH, provides training and technical assistance to child care providers. A primary objective is to increase the capacity of child care providers to serve children with disabilities. The CEDARR's initiative will be required to consider childcare options for children, when indicated. The state Medicaid office, through the CEDARR's initiative, is seeking methods of funding for therapeutic day care and has recently funded several "Head Start-like" child care networks to provide comprehensive child care networks.

HEALTH has partnered with RIDE, DCYF, and DHS to develop responsive childcare options within Rhode Island. HEALTH is also working with Childspan, the DHS funded training system for child care providers, to initiate a series of professional development activities targeted specifically toward providers of infant and toddler services. These activities are aimed at increasing provider competencies to deliver quality care to all young children and families, and especially to those most in need.

2. Issues that were identified in monitoring conducted by the State; actions required to resolve them, including technical assistance, sanctions, etc; steps taken to improve State monitoring and technical assistance; and areas identified for further improvement

The following information is a compilation of the last four review summaries for all seven EI provider sites. HEALTH monitors quality assurance and quality improvement by systematically reviewing a randomly selected percentage of EI records on a quarterly basis. These reviews address federal, state, and program requirements. They focus on the content and substance of the family records, which in turn reflect services provided to all families.

The average number of children enrolled in EI per quarter is 973. The number of EI Medicaid records reviewed for the past year is 105. The overall strengths determined from these record reviews are:

- Professional development activities for staff and consultants continues to improve as ongoing trainings are scheduled through the “Rhode Island Early Intervention Training Center Project.” Additionally, HEALTH continues to support provider sites as they schedule trainings that may address a variety of needs. Technical assistance is available throughout the year for auxiliary supports.
- EI providers are moving toward continuity in staffing with more EI specific disciplines such as occupational therapy, physical therapy, etc. This focus is believed to be best practice for a more comprehensive service package.
- The overall implementation of the Parent Consultant Confidentiality form, which is given to families during intake, is completed. Parent consultant involvement has increased dramatically, giving choices for levels of intervention and parent pairing that is positively impacting on quality for all families.
- Each of the seven sites housing EI is making strides toward utilizing the natural environment of the child and their family. The diversity of EI’s population drives this goal and heightens the challenges for ongoing natural setting service delivery. Continued efforts for linkages between EI and community services remain an important focus for all provider sites.
- Each of the provider sites conduct extensive outreach for their community and will continue to expand efforts to enhance both community and professional collaboratives.

Areas of need and actions being taken:

- The total of IFSP implementation time lines to be over the 45-day mark, averages 25% for all seven sites. Health is developing “site specific” action plans to address this issue.

- The need to implement a consistent referral feedback form is recognized as an issue for all sites - HEALTH is looking towards a more uniform documentation system that may be included in the IFSP to address this issue.
- The need to aggressively pursue natural environments as the first choice for service delivery - HEALTH is looking for a 90% compliance rate for service in the child and family's natural setting.
- The timely completion of the Health Care Finance Administration (HCFA) document sent to primary care providers for review and signature - the collaboration between providers and primary care physicians is an ongoing effort.
- All providers should be moving toward completion of private insurance contracts. This continues to be an important goal for HEALTH.

As part of HEALTH's Quality Assurance team, RIPIN's EI Parent Consultant Program distributed a Family Satisfaction Survey to all families enrolled in EI as of June 2001. Surveys were returned by early September 2001. The purpose was to assess strengths and weaknesses of EI services as viewed by families and then to address issues identified in real time. The EI parent consultants on an ongoing basis will also utilize this survey as they strive to survey all families receiving services in EI.

1,367 surveys were distributed in English and in Spanish; 68 were returned undeliverable, and 387 were returned completed. Strong themes emerged in many areas as indicated by the numerical results, as well as by the parent's comments:

- 95% of families said that they were welcomed into the EI system in a friendly and timely manner.
- 98% said that the EI evaluation was explained in a way that was understandable.
- 91% of families feel that the services they receive are respectful of their choices, race, religion, and life experiences.
- 85% are satisfied that the EI services are provided in natural environments (another 5.5% said they were satisfied "for the most part").

This data is supported by the families' comments, which overwhelmingly identified services in natural (community) environments as a strength. Other family-identified strengths included the trusting, supportive relationship that is developed between families and staff (most notably the service coordinator) so that the service coordinator can address the family's questions and concerns. This included the ability of the staff to assist and teach parents/families how to address their child's goals themselves in between visits.

Areas of concern included waiting lists for specific services; the need for complete, understandable information and options; numerous changes in service providers; and the need for more staff to provide services. 65.5% of families indicated that they knew how to access their procedural safeguards, which means that 34.5% of families do not or do not understand how to do this.

Lastly, a theme that emerged statewide and across all providers is the need to extend EI services beyond the age of three years - many said up to five years, while others said up to four years of age.

3. Accomplishments related to the State's early intervention system, including benefits received by families as a result of their participation

- A fee-for-service reimbursement system has replaced grant-based funding for certified providers. EI services are reimbursed to providers at the present state Medicaid rates. Benefits of fee for service include increased services to families, clearer understanding of what services are being purchased, and increased financial resources for certified providers. Additionally, the new system assures maximization of Medicaid reimbursement through the new EIMIS. The state Medicaid staff provides training and ongoing technical assistance to staff in the EI system.
- The new EIMIS at all sites serves as both a tool for quality assurance at the state level and a management tool for the provider; its data serves as the basis for the cost reimbursement this effort. Fine-tuning, technical assistance and training are continually provided.
- HEALTH is working with a newly established New England work group comprised of all New England EI state agency training authorities to explore the best approach for a certification process for EI service coordinators. In Rhode Island, URI, through the Rhode Island EI Training Center, is developing trainings, including goal writing, as well as a defined cadre of parent/professional training teams. The possibility of a mentorship program, such as the one in Massachusetts, is also being considered. Competent and experienced Service Coordinators are the linchpins of a quality EI system. Competencies will be totally developed, as well as supportive training. Rhode Island will continue to be participatory in the New England Forum, which represents CSPD across the New England states.
- Special emphasis on the IFSP process: A new, more family friendly IFSP form, which fully integrates with the EIMIS, has been developed and integrated in the EI system. HEALTH provides on-site training to EI provider staff on utilization of this form and the IFSP process.
- Outreach: EI funds have been earmarked to increase home visiting options for hard-to-find/reach children who are clearly at risk. Increased responsiveness to locating at risk families through the Family Outreach/Home Visiting Program (FOP) is an important effort by the EI system to assure that all eligible families have access to quality EI services.

Home visiting agencies must indicate how culturally and linguistically appropriate services will be delivered to racial and ethnic minority populations. They also must describe how they will locate families that are difficult to reach; for example, how they would contact a family without a telephone or that speaks a language other than English or Spanish. HEALTH is providing additional funding for families that receive visits if they meet one of the following criteria:

- Are "risk response" follow-up visits, i.e., they are referred into the program by a HEALTH program, such as lead or immunization, or a physician refers them
- The FOP or referral source is unable to locate the family for more than a month through the usual mechanisms

- The family does not speak English or Spanish
- The family has greater than four risk factors as determined by Level 1 Assessment. Level I assessment involves the collection of demographic, child, and parental characteristics which put a child at developmental or environmental risk, usually completed within 48 hours of birth. Information is collected primarily from the mother's and baby's medical records, the birth certificate worksheet, interfacing with hospital social workers, obstetric and pediatric nurses and physicians, and from direct family contact when indicated. Referral of families at risk is made to community based home visiting services for a home assessment and family support.
- Natural Environments: Work continues on expanding family options for EI natural environments. Efforts include training of staff, an enhanced reimbursement rate to EI providers for childcare, quality assurance monitoring, and ongoing discussion with the CEDARR's Implementation Team.

4. Description (including approximate dollar amount) of how Part C funds were used during the fiscal year

The total funding for EI in Rhode Island is as follows:

	PART C	STATE	MEDICAID
Personnel	\$ 63,266	\$ 350,100	\$ 260,417
Direct Services	1,634,817	4,519,557	1,026,842
Operating	81,292	106,827	47,172
Indirect Services	32,700	--	--
TOTAL:	\$1,812,075	\$4,976,484	\$1,334,431

In EI, approximately 90% of RI's budget from IDEA, Part C, was allocated to the seven statewide EI Providers and was directed into services at the local level. These funds were used to support IDEA, Part C, mandated components and to enhance community systems development. The seven statewide EI Providers played a leadership role in a number of community initiatives. In addition, they were partners with other agencies in local efforts, such as the Local Coordinating Councils (LCCs), Child & Adolescent Service System Program (CASSP), Child Opportunity Zones (COZs), etc. Community system development was facilitated also by Part C administrative and EI provider participation in numerous interagency efforts, e.g., the Rhode Island Hearing Assessment Program (RIHAP) Follow-up Committee, a group charged with assuring appropriate coordination of services among agencies for a specialized population (e.g., infants identified with hearing impairments).

5. Description of ongoing systemic challenges to EI in Rhode Island to implementation of the early intervention system

Certification process for providers of comprehensive early intervention services: The certification process for providers of EI services will be reopened in October 2002 for existing providers, with certification beginning January 2003. A certification process for possible new providers will begin in January 2003. Additionally, it is anticipated that the specialty services certification process will begin in 2003, with specialty certification beginning in 2004.

Continuous quality improvement: Efforts to ensure the establishment of a system of program accountability, system effectiveness, quality assurance, monitoring, evaluation, and technical assistance will continue, with parent consultants being fully integrated in the QA system. A plan for incentives will be explored. QA is a continually evolving process.

Fee-for-service reimbursement system: The fee-for-service reimbursement system for certified providers at the present state Medicaid rates is an ongoing process.

EIMIS: The EIMIS is both a tool for quality assurance at the state level and a management tool for the provider; its data serves as the basis for the cost reimbursement system. The EIMIS will interface with KidsNet, HEALTH's automated tracking and follow-up system which links pediatric public health programs to each other and to health care providers, to maximize the sharing of health data for children in EI, once both systems are able to accommodate this process.

Parent Consultant Program supports families in EI: The goal is to have one parent consultant per one hundred families. Additionally, parent consultants will be fully integrated in the quality assurance process.

Reconstitution of the ICC: Representation on the ICC has been broadened to reflect a wider EI system. The ICC is identifying priority issues to address in the coming year. Additionally, an ICC Parent Leadership Team has been created to increase outreach through parent leadership development, so that children in need of EI services and supports in Rhode Island will be enrolled and receiving appropriate services and supports at an earlier age.

Private insurance mandate for EI services: Legislation has been resubmitted, which mandates private insurance companies to pay for medically necessary EI services up to \$5,000 annually. This legislation is an integral part of the state's comprehensive approach to funding and providing quality EI services to infants and toddlers with disabilities and their families.

Natural Environments: Work continues on expanding family options for EI natural environments. Efforts will be made to ensure that EI Providers are comfortable with a common approach to services in natural environments.

Additional EI clinical expertise established at HEALTH: The Best Practices Advisory Group is operational; additional experts will be contracted.

Head Start Collaboration: HEALTH EI will work to solidify and expand relationships around early childhood among HEALTH, Head Start, and certified EI Providers.

Expanding Staff: Efforts to increase the number of competent professionals to serve infants and toddlers with disabilities will continue. An interdepartmental planning group has begun discussions regarding appropriate strategies for working with Rhode Island's institutes of higher education.

6. Reason for slippage if objectives are not met: Not applicable.

7. Description of State's credentialing system for both professionals and paraprofessionals to support the implementation of the early intervention system

All professional personnel in EI programs, whether employed on a full-time or part-time basis or under a contractual agreement, for whom certificates or licenses are required by state law and regulation, are certified or licensed.

In Rhode Island, appropriate professional requirements means entry-level requirements that are based on the highest requirement in the State, applicable to the profession or discipline in which a person is providing EI services.

"Highest requirements in the State applicable to a specific profession or discipline" means highest entry-level academic degree needed for state approved or recognized certificate, license, registration, or other requirements that apply to a profession/discipline.

Nothing, however, prohibits the use of paraprofessionals and assistants who are appropriately trained and supervised, in accordance with State law, regulations, or written policy, to assist in the provision of EI services to infants and toddlers with disabilities.

Pursuant to the 1997 IDEA Amendments, Part C, the State has adopted a policy that includes making ongoing good-faith efforts to recruit and hire appropriately and adequately trained personnel to provide EI services to infants and toddlers with disabilities, including, in a geographic area of the State where there is a shortage of such personnel, the most qualified individuals available who are making satisfactory progress toward completing applicable course work necessary to meet the State's required standards within three years.